SECTION
SERVICES

SUBJECT
MFP Regional Transition Coordinator

REFERENCES: New Demonstration Service – defined in the MFP Operational Protocol

DEFINITION

Regional transition coordinators will provide supports for consumers' needs as they transition from institutions to the community.

- Transition coordinators will work with a team, including the consumer, family members, institutional providers, discharge planners, peer mentor/advocate, and community providers (including CILs) to develop a transition plan and oversee its implementation.

- Transition coordinators will coordinate services around the transition, including the transition services (Example: housing assessment, home modifications, vehicle modifications, utility deposits, connecting participants to peer mentors, working with local housing coordinators, visiting potential housing options, coordinating moving day, and selecting other MFP demonstration services needed by the consumer to successfully transition).

COVERED SERVICES

MFP Regional Transition Coordinator Services include the following:

- Meet MFP applicant (and family, guardian, or others involved as applicable) within 30 days of referral
- Provide overview of MFP program
- Learn more about the applicant and his/her wishes
- Discuss and clarify options (provide options counseling)
- The applicant confirms his/her desire to participate or not (must complete signed consent form)
- In collaboration with the participant, define the participant's support network, guardian, and person-centered planning team
- Review criteria for guardian participation
- Request documentation to confirm participant meets level of care or needs-based criteria
- Work closely with waiver case manager (this requirement won't be necessary if the Case Manager and Regional Transition Coordinator are the same).
- Confirm length of stay in an institutional setting
- Confirm Medicaid eligibility
- Work with ADRC, in-patient facility, OPA, and family to begin qualifying participant for Medicaid, if necessary
- Inform participants of MFP participation once eligibility is confirmed

- Complete the baseline Quality of Life Survey with participant who is over 18 years old prior to transitioning out of the institution if possible.
- Review consumer assessments, including level of care and functional needs assessments
- Explore participant's preferences and expectations for living and services
- Gather information on service and support needs and resources by assessing needs in:
    - Medical
    - Social
    - Housing
    - Transportation
    - Educational/Vocational
    - Advocacy
    - Financial
    - Psychological
    - Substance abuse/addiction
- Develop person-centered plan
- Continue to determine details and implement components of the person-centered plan through moving day
- Determine details and implement 24/7 emergency back up plan
- Determine details and implement risk/mitigation plan
- Create draft discharge plan (i.e. transition plan to waiver/State Plan services)
- Conduct readiness review
- Prepare for move
- Ensure Medicaid eligibility day before discharge

SERVICE REQUIREMENTS

The MFP Regional Transition Coordinator is a person identified during the referral and eligibility process with consideration to the person-centered plan. This person will provide one-on-one support for a participant during the MFP transition process from an institution into the community.

The Regional Transition Coordinator demonstration service begins when the following two things are on file with the State Transition Coordinator:
1) The approval letter is mailed to the agency and the Regional Coordinator signs and returns the "Regional Transition Coordinator Acceptance Form"; **and**
2) The participant or guardian signs and returns the "Informed Consent".

The Regional Transition Coordinator demonstration service ends when one of the two following things occur:
1) the day after moving day; or
2) upon failure to move (for example, due to withdrawal from MFP, hospitalization, decline, death).

If the Regional Transition Coordinator is also the case manager or regional staff, the role of case manager or regional staff will be assumed the day after transition and will continue to meet the requirements of the qualified waiver program.

FEES

This fee for the Regional Transition Coordinator is paid for both a successful and an unsuccessful transition. See below for clarification of billing:

Billing for successful transitions:
A transition is successful if the participant moves to the community for a minimum of one day. A successful transition can be billed through Xerox on claim form 1500 effective moving day. Prior authorization is required for all MFP demonstration services.

Unit of Service:	1 Transition
Rate:	$5,000

PROCEDURE CODE/MODIFIER

H0043/UA

Billing for unsuccessful transitions:
A transition is unsuccessful if The Regional Transition Coordinator begins transition activities based on the date of the approval letter from the MFP program and receipt of "Informed Consent" signed by the participant or guardian and the participant does not move to the community for a minimum of one day.

Unsuccessful transitions are those that fail to make it to moving day. Reasons for failure could include withdrawal from MFP, Medicaid/waiver ineligibility, hospitalization, decline, and death.

Payment through MFP for an unsuccessful transition will consider factors such as duties performed under this service definition and amount of time spent on the transition prior to move. For example, if the majority of the duties have been completed, payment could be made for an unsuccessful transition. If some of the duties have been completed and an extensive amount of time has been spent, payment could be made for an unsuccessful transition. Payment for an unsuccessful transition will be approved and paid at the discretion of the MFP Program.

The agency will directly invoice the MFP Program for the unit amount along with a W-9 if needed. Invoices will be sent to:
SLTC-MFP
PO Box 4210
Helena, MT 59604